APPENDIX H

CLINICAL PRIVILEGE SHEETS FOR ADVANCED PRACTICE NURSES

1. Advanced Practice Nurses are defined as credentialed health care practitioners granted privileges within the scope of their practice. The three advanced practice specialties recognized by Navy Medicine are nurse anesthetist, nurse-midwife and nurse practitioner with a focus on family practice, pediatrics or women's health.

2. The clinical privilege sheets contained in this appendix are arranged by clinical specialty. These sheets are used in the application and granting of professional staff appointments to delineate the specific scope of care, i.e., clinical privileges. For each specialty area, the privileges are divided into two categories, core privileges and supplemental privileges.

a. Core privileges

(1) Constitute a single entity. This is not a list from which applicants may choose the privileges they wish to request.

(2) Describe the baseline scope of care for fully-qualified DON practitioners in each of the identified specialty areas.

(3) Are standardized and must not be modified by MTFs/DTFs. Forward suggested modifications to core privileges to BUMED-M3M (Medical Operations Support) via the appropriate specialty advisor.

b. Supplemental privileges

(1) Are delineated on an item-by-item basis. Provider must write yes or no beside the supplemental privilege, on the privilege sheet. The area labeled "other" is used to delineate privileges not contained within the core privileges or specifically listed in the supplemental category for that specialty.

(2) May be customized by MTFs/DTFs by adding, deleting or modifying items to make them specific to their facility. This action does not require BUMED approval.

3. Practitioners must use only those privilege sheets appropriate for their clinical specialty.

4. Health care practitioners are not required to be privileged to provide emergency care. All personnel are expected and authorized to render care necessary to save the life or protect the welfare of a patient in an emergency situation to the degree permitted by their licensure, training, applicable laws and Navy regulations.

5. Advanced practice nurses may prescribe all medicines (including Schedule II through V), durable medical goods and other equipment and supplies required within their scope of practice.

6. Criteria for advanced practice nurses core privileges

a. Education:

(1) Graduation from a master's or doctoral degree program which prepares an individual in nurse anesthesia, nurse-midwifery or as a nurse practitioner and is approved by an organization authorized by the Department of Education to accredit schools of nursing.

(2) Graduation from a clinical master's degree program in nursing and satisfactory completion of a formal post-graduate certificate program in the desired specialty granting graduate level academic credit. These programs are most commonly referred to as post-master's certificate programs.

(3) Nurses who graduated from an approved practitioner certificate program or received a graduate degree in a nursing or related specialty and currently hold privileges in these advanced practice specialties are considered to have met the educational requirement.

(4) Nurses with educational preparation as described in paragraph 6a(3) and currently hold privileges and/or actively practice in these advanced practice specialties outside Navy Medicine will be evaluated on a case-by-case basis using the following criteria:

(a) Evidence of significant work experience in selected specialty area.

(b) Evidence of competence and performance excellence as noted in recent performance recommendation for employer reflects.

(c) Evidence of continuous training in specialty area.

(d) Recommendation from relevant specialty leader.

(5) As educational systems evolve, some universities are not granting degrees specifically titled "nursing." Where these programs are not so titled, the relevant specialty leader will review and evaluate course content.

b. Certification. Must obtain and maintain certification by the relevant certification body for the given advanced practice nursing specialty. National certification must be obtained within 12 months of graduation from an approved program. In certain unusual

circumstances, a waiver of this 12-month requirement will be considered and must be obtained from the relevant specialty leader. Approved certification jurisdictions are in this instruction.

c. Possession of a current, valid and unrestricted license as a registered professional nurse, per this instruction.

d. Current clinical competence.

e. No health status contraindications to granting clinical privileges as delineated.

7. Criteria for advanced practice nurses (APN) supplemental privileges:

a. Criteria for core privileges.

b. Compliance with specialty-specific criteria, which have been endorsed by the ECOMS and approved by the privileging authority.

c. Demonstrated experience and competence in techniques requiring special skills. Certification necessary in certain identified procedures.

8. Core privilege sheets are included in this appendix for the following APN specialties:

Certified Nurse Anesthetist
Certified Nurse Midwife
Family Nurse Practitioner
Pediatric Nurse Practitioner
Women's Health Nurse Practitioner

DEPARTMENT OF THE NAVY

CERTIFIED NURSE ANESTHETIST - CORE PRIVILEGES

The nurse anesthetist is a licensed independent practitioner responsible for the anesthetic management of patients in all age groups rendered unconscious or insensitive to pain and emotional stress during surgical, obstetrical, dental and certain medical procedures, including preoperative, intraoperative, and postoperative monitoring, evaluation and treatment:

* Management of fluid, electrolyte, and metabolic parameters
* Resuscitation
* Management of malignant hyperthermia
* Manipulation of cardiovascular parameters
* Manipulation of body temperature
* Intravenous conscious sedation and analgesia
* Treatment of hypovolemia from any cause
* Management of respiratory parameters
* Treatment of unconscious patients
* Initiation and management of patient-controlled analgesia, intrathecal and epidural

Procedures:

* Local and regional anesthesia with and without sedation, including topical and infiltration, minor and major nerve blocks, intravenous blocks, spinal, epidural and major plexus blocks
* General anesthesia, including invasive monitoring, respiratory therapy airway management to include emergency cricothyroidotomy
* Release of patients from the care of the anesthesia service
* Provision of anesthesia-related consultative services for other health care providers when requested

DEPARTMENT OF THE NAVY

NURSE ANESTHETIST - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

(Continued)

_____ Anesthesia for cardiac operations with cardiopulmonary bypass
_____ Anesthesia for elective procedures on neonates who are physical status III or higher
_____ Diagnostic and therapeutic blocks, excluding permanent nerve blocks for acute pain, upon request of a physician

Other:

Treatment Facility: _____ Date Requested: _____

Practitioner Name: _____ Date Approved: _____

DEPARTMENT OF THE NAVY

CERTIFIED NURSE MIDWIFE - CORE PRIVILEGES

Assessment and management of health care of women throughout their life cycles focusing on the childbearing process, inclusive of:

* Health, psychosocial, and OB/GYN history and physical examination
* Prenatal care of the uncomplicated obstetric patient
* Consultation with other specialists, clinics or health resources as indicated
* Management of complicated pregnancy collaboratively with an obstetrician/ gynecologist
* Ordering of routine screening laboratory tests and radiographic procedures
* Prescription of contraceptive agents to include insertion of IUD and fitting diaphragms
* Assessment and treatment of OB/GYN patients with acute episodic illness and consultation with appropriate medical officer when needed
* Development of health promotion and maintenance plans, including disease prevention and health education and counseling
* Provision of periodic health screening
* Assessment and treatment of patients with minor gynecological problems and sexually-transmitted diseases
* Treatment of male partners of OB/GYN patients with sexually transmitted diseases
* Evaluation of fetal well-being by electronic monitoring and interpretation of stress and non stress tests
* Diagnosis of labor, performance of admission history and physical examination
* Admission and discharge privileges to OB/GYN service
* Management of labor inclusive of routine inpatient orders, amniotomy, external and internal monitoring, initiation of induction/augmentation agents and analgesia using intramuscular and intravenous narcotics and potentiators
* Management of vertex delivery inclusive of local, pudendal, and paracervical block anesthesia, performance and repair of episiotomy
* Assessment and management of uncomplicated postpartum patients
* Care of newborn including airway management, resuscitation endotracheal intubation, assignment of Apgar scores and initial examination in the delivery room

CERTIFIED NURSE MIDWIFE - SUPPLEMENTAL PRIVILEGES
Write "Yes" or "No" by each supplemental privilege

_____ Application of outlet forceps to deliver infant
_____ Application of vacuum extractor to deliver infant
_____ Manual removal of placenta
_____ Uterine exploration
_____ Repair of third degree lacerations
_____ Repair of fourth degree lacerations
_____ Repair of cervical lacerations
_____ Genetic counseling
_____ Ultrasonography, level I
_____ Endometrial biopsy
_____ Colposcopy, cervical and endocervical biopsy and cryotherapy
_____ Assistance to obstetrician/gynecologist during operative procedures
_____ Large loop electrical excision procedures (LEEP)
_____ Vulvar and vaginal biopsy
_____ Insertion and removal of subcutaneous progestin implants
_____ Fitting of cervical cap

Other:

Treatment Facility: _____ Date Requested: _____

Practitioner Name: _____ Date Approved: _____

DEPARTMENT OF THE NAVY

FAMILY NURSE PRACTITIONER - CORE PRIVILEGES

Comprehensive assessment, examination, diagnosis, treatment and consultation of all age groups to include:

* Triage of patients with life-threatening conditions
* Counseling patients with common marital or family problems
* Immunizations for adults and children
* Minor acute episodic illnesses in adults
* Well baby examinations
* Counseling of patients with minor psychosexual problems
* Management of uncomplicated pregnancies
* Contraceptive counseling
* Minor acute episodic illnesses in obstetrical patients
* Minor gynecological conditions and sexually-transmitted diseases
* Postpartum care of uncomplicated patients
* Counseling of patients with psychosocial problems associated with pregnancy and delivery
* Gynecological cancer-screening care to include PAP smear and breast examination
* Physical, developmental and psychosocial status of the infant, preschool, school aged and adolescent child including initiation of appropriate screening tests
* Minor acute episodic illnesses in children
* Chronic or long-term illnesses in adults
* Ordering laboratory studies, electrocardiograms and radiographic procedures
* Consultation or referral to appropriate physicians, clinics, or other health resources as indicated
* Medical histories and physical examinations

FAMILY NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

_____ Incision and drainage of thrombosed hemorrhoids, cysts and minor abscesses

_____ Administration of local anesthesia for wound infiltration and suturing of minor lacerations not involving nerves, tendons or vessels

_____ Removal of minor dermatological growths

_____ Removal of toenails or fingernails

_____ Insertion of intrauterine device and subcutaneous progestin implants

DEPARTMENT OF THE NAVY

FAMILY NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

(Continued)

_____ Endometrial biopsies
_____ Colposcopy
_____ Occupational and medical surveillance program physical examinations for workers engaged in hazardous occupations per Navy Occupational Safety and Health, Occupational Safety and Health Administration, and Navy occupational medicine instructions and directives

Other:

Treatment Facility: _____ Date Requested: _____

Practitioner Name: _____ Date Approved: _____

DEPARTMENT OF THE NAVY

PEDIATRIC NURSE PRACTITIONER - CORE PRIVILEGES

Comprehensive assessment, examination, diagnosis, treatment and consultation of the infant, preschool, school age and adolescent child including:

* Physical, developmental and psychosocial status, including initiation of appropriate screening tests for vision, hearing, speech and developmental levels
* Consultations or referrals to appropriate specialty areas, including physicians, allied health professionals, developmental programs and other health resources
* Ordering of laboratory studies, electrocardiograms and radiographic studies
* Immunizations
* Development of health promotion and comprehensive health maintenance plans to include disease prevention, safety issues, health screening and developmental issues
* Management of acute, non life-threatening conditions
* Identification of high-risk families for abuse and neglect using appropriate federal and local support agencies. Guidance and counseling to high-risk families
* Management of chronic illnesses
* Counseling of families and individuals identified with developmental disabilities, emotional problems, adjustment disorders and other conditions
* Referral to federal, State and local community and educational resources as appropriate

PEDIATRIC NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

_____ Assessment and treatment of patients with minor gynecological problems and sexually-transmitted diseases
_____ Performance of PAP smears
_____ Contraceptive counseling for adolescents to include the prescribing of contraceptives

DEPARTMENT OF THE NAVY

PEDIATRIC NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

(Continued)

_____ Management of minor trauma and orthopedic injuries
_____ Inpatient management of non high-risk newborns
_____ Administration of local anesthesia for wound infiltration and suturing of minor lacerations not involving nerves, tendons or blood vessels

Other:

Treatment Facility: _____ Date Requested: _____

Practitioner Name: _____ Date Approved: _____

DEPARTMENT OF THE NAVY

WOMEN'S HEALTH NURSE PRACTITIONER (OB/GYN NURSE PRACTITIONER) - CORE PRIVILEGES

Assessment and management of health care of women throughout the life cycle inclusive of:

* Health, psychosocial, OB/GYN history and physical examination
* Prenatal care of the uncomplicated obstetric patient
* Consultation with other specialists, clinics or health resources as indicated
* Ordering of routine screening laboratory tests and radiographic procedures
* Prescription of contraceptive agents to include insertion of IUD and fitting diaphragms
* Assessment and treatment of patients with acute episodic illness and consultation with appropriate medical officer when needed
* Development of health promotion and maintenance plans, including disease prevention, health education and counseling
* Provision of periodic health screening
* Assessment and treatment of patients with minor gynecological problems and sexually-transmitted diseases
* Treatment of male partners of OB/GYN patients treated for sexually-transmitted diseases

WOMEN'S HEALTH NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write “Yes” or “No” by each supplemental privilege

_____ Insertion and removal of subcutaneous progestin implants
_____ Fitting of cervical cap
_____ Colposcopy, cervical and endocervical biopsy, cryosurgery
_____ Endometrial biopsy
_____ Vulvar and vaginal biopsy
_____ LEEP procedures
_____ Genetic counseling
_____ Ultrasonography level I
_____ Assistance to obstetrician/gynecologist during operative procedures

DEPARTMENT OF THE NAVY

WOMEN'S HEALTH NURSE PRACTITIONER - SUPPLEMENTAL PRIVILEGES

Write "Yes" or "No" by each supplemental privilege

(Continued)

Other:

Treatment Facility: _____ Date Requested: _____

Practitioner Name: _____ Date Approved: _____

APPENDIX I

PRIVACY ACT STATEMENT INDIVIDUAL CREDENTIALS FILE (ICF)/INDIVIDUAL PROFESSIONAL FILE (IPF)

1. Authority. The authority for collection of information including SSN is found in Section 301, Title 5, United States Code.

2. Principal purpose for which information is intended to be used. This form provides the advice required by the Privacy Act of 1974. The personal information will facilitate and document your credentials. The SSN of the member is required to identify and retrieve credentials and professional files.

3. Routine uses. The primary use of this information is to provide, plan, and coordinate member's credentials and privileging information. This will aid the privileging authority to review the member's academic qualifications, make a determination on the member's clinical competence, and grant appropriate privileges requested.

4. State whether the disclosure is mandatory or voluntary and the effect on the individual of not providing information.

a. For all personnel, the requested information is mandatory because of the need to document all credentials, privileging, and quality assurance (quality management) data.

b. If the requested information is not furnished, establishment of eligibility for appointment to the medical staff and granting of privileges will not be possible.

c. This all-inclusive privacy act statement applies to all requests for personal information made by personnel for credentials verification purposes and shall become a permanent part of the member's ICF or IPF.

d. By signing this form, the individual acknowledges that he or she has been advised of the foregoing. If requested, a copy of this form will be furnished to the member.

Member signature: _____

Member SSN: _____

Date: _____

APPENDIX J

PERSONAL AND PROFESSIONAL INFORMATION SHEET
PRIVILEGED PROVIDER

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "Yes" answers require full explanation in the comments section or on an attached sheet of paper. Indicate the section number and subsection for those items being commented upon in attachments.

Name of Command:_____

1. General

Last Name, First, MI: _____
Alias (Last, First, MI): _____
Grade: _____ Desig: _____ SSN: _____
Date of Birth: _____ Branch of Service:_____
Citizenship (Country): _____Reporting Date:_____
PRD: _____
Specialty(ies): _____AQD(s)_____
Office Telephone Number: (_____) _____-_____
Office Fax Number: (_____) _____-_____
Office E-mail Address: _____
Office Address: _____
Local Address: _____
Home Telephone Number: (_____) _____-_____

2. Professional Education and Training (most recent first)

a. Basic Qualifying Degree (e.g., MD, DO, MSW, or PhD)

Institution	Address	Credential	From	To

b. Internship (INT), Residency (RES), and Fellowship (FEL).

Institution	Address	Type	From	To

3. Qualifying Certifications and Specialty Boards. Certification or recertification, issue and expiration dates. _____
_____

4. List all Licenses or Certificates by State or Federal Agency. Include all those that have been either voluntarily or involuntarily withdrawn.

a. License Information

License Number	State	Type	Expires

b. Drug Enforcement Agency (DEA) Numbers

DEA Number	Expires	DEA Number	Expires

5. All Professional Assignments, Military and Civilian

_____
_____
_____
_____

6. Academic Appointments

Institution	Full Address	Position	From	To

7. Professional Affiliations

Organization	Full Address	Office	From	To

8. Continuing Education Credits for Past 2 Years. (For initial appointment only. Use practitioner's training file for renewal.)

a. Academic

Institution	Course Title/Subject	Credit Hours	Date

b. Contingency Training (indicate certified [C] or trained [T]).

Training	C/T	Expiration	Training	C/T	Expiration
BLS			ACLS		
ATLS			CTTC**		
C-4*			NALS		
PALS					

* C-4 (Combat Casualty Care Course)
** CTTC

9. Health Status and History. (Answer "yes" or "no." Explain all "yes" answers in comments section.)

____ a. Do you currently have any physical or mental impairments that could limit your clinical practice?

____ b. Are you currently taking any medications?

____ c. Do you have a potentially communicable disease?

____ d. Have you been hospitalized for any reason during the last 5 years?

____ e. Have you ever been hospitalized for or diagnosed with a major psychiatric disorder?

____ f. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?

____ g. Have you ever been involved in the illegal use of controlled substances?

Comments:
_____
_____
_____

10. Malpractice, Licensure, Privileging Action and Legal History. (Answer "yes" or "no." Explain all "yes" answers in comments section.)

____ a. Have you ever been denied staff appointment or had your privileges suspended, limited, revoked or renewal denied?

____ b. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)

____ c. Have you ever been a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)

____ d. Have you ever voluntarily or involuntarily withdrawn, reduced, terminated, lost or been denied your staff appointment?

____ e. Have you ever voluntarily or involuntarily withdrawn, reduced, terminated, lost or been denied your clinical privileges?

____ f. Was there previously any successful or currently pending challenges, investigations, revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial or with-drawl to any licensure, certification, or registration (State, district or DEA) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?

Comments: _____
_____
_____

11. Moonlighting Information. (Specify other facilities where you currently hold clinical privileges.)

Institution	Full Address	Department	Priv Spec

12. Other Information. (Include any additional information that you wish to bring to the attention of the privileging authority.)

_____
_____
_____
_____
_____
_____
_____

_____ _____
(Signature) (Date)

PERSONAL AND PROFESSIONAL INFORMATION SHEET
NON-PRIVILEGED PROVIDER

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "Yes" answers require full explanation in the comments section or on an attached sheet of paper. Indicate the section number and subsection for those items being commented upon in attachments.

Name of Command:_____

1. General

Last Name, First, MI: _____
Alias (Last, First, MI): _____
Grade: _____ Desig: _____ SSN: _____
Date of Birth: _____ Branch of Service:_____
Citizenship (Country): _____Reporting Date:_____
PRD: _____
Specialty(ies): _____
Office Telephone Number: (_____) _____-_____
Office Fax Number: (_____) _____-_____
Office E-mail Address: _____
Office Address: _____
Local Address:_____
Home Telephone Number: (_____) _____-_____

2. Professional Education and Training (most recent first)

a. Basic Qualifying Credential (e.g., BS, MS, PhD)

Institution	Address	Credential	From	To

b. Special Education. (Include professional course of 2 week's duration or greater, Navy Leadership Training or other relevant programs that pertain to practice.)

Institution	Address	Specialty	Type	From	To

3. Specialty Certifications

Certification	Number	Agency	Issue Date	Expires

4. List all Licenses or Certificates by State or Federal Agency. Include all those that have been either voluntarily or involuntarily withdrawn (include DEA certification).

a. License Information

License Number	State	Type	Expires

5. Relative Work Experience. (List chronologically, most recent first.)

_____
_____
_____
_____
_____

6. Membership in Professional Organizations

Organization	Full Address	Office	From	To

7. Continuing Education Credits for the Past 2 Years

a. Academic

Institution	Course Title/Subject	Credit Hours	Date

b. Contingency Training (indicate certified [C] or trained [T])

Training	C/T	Expiration	Training	C/T	Expiration
BLS			ACLS		
ATLS			CTTC		
C-4			NALS		
PALS					

8. Personal Awards and Letters of Recognition (List chronologically, most recent first.)

Award/Recognition	Month/Year Awarded

9. Publications (List chronologically, most recent first.)

Title/Publication	Publication Date

10. Health Status and History (Answer "yes" or "no." Explain all "yes" answers in comments section).

____ a. Do you currently have any physical or mental impairments that could limit your clinical practice?

____ b. Are you currently taking any medications?

____ c. Do you have a potentially-communicable disease?

____ d. Have you been hospitalized for any reason during the last 5 years?

____ e. Have you ever been hospitalized for or diagnosed with a major psychiatric disorder?

____ f. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?

____ g. Have you ever been involved in the illegal use of controlled substances?

Comments: _____
_____
_____
_____
_____
_____

11. Malpractice, Licensure, Reduction in Clinical Scope and Legal History. (Answer "yes" or "no." Explain all "yes" answers in comments section.)

____ a. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)

____ b. Have you ever been a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)

____ c. Has there been previously successful or currently pending challenges, investigations, revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial, or withdrawal to any licensure, certification, or registration (State, district, or DEA) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?

Comments: _____
_____
_____
_____
_____
_____

12. Moonlighting Information. (Specify other facilities where you currently work.)

Institution	Full Address	Department	Priv Spec

13. Other Information. (Include any additional information that you wish to bring to the attention of the privileging authority.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
(Signature) (Date)

APPENDIX K

SAMPLE APPLICATION FOR PROFESSIONAL STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

(Date)

From: (Name of practitioner)
To: (Privileging authority)
Via: (1) Medical Staff Services Professional
(2) Appropriate chain of command

Subj: STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

Encl: (1) Clinical privilege sheet
(2) Individual Credentials File (ICF) or Appendix N if ICF is not available

1. Request (see end note; check the applicable paragraph):

____ a. Initial staff appointment with clinical privileges as reflected in enclosure (1).

____ b. Active staff appointment with clinical privileges as reflected in enclosure (1).

____ c. Renewal of active staff appointment with clinical privileges, ____ with or ____ without changes from current privileges, as reflected in enclosure (1).

____ d. Affiliate staff appointment with clinical privileges as reflected in enclosure (1).

____ e. Modification of clinical privileges as reflected in enclosure (1) to include: _____

____ f. Active staff appointment with clinical privileges as reflected in enclosure (1), based on the active staff appointment with core and supplemental clinical privileges granted at my previous command.

____ g. Active staff appointment with clinical privileges, as reflected in enclosure (1), based on the successful completion of my Navy full-time inservice.

_____ Internship
_____ Residency
_____ Fellowship

2. Enclosure (2) provides information in support of this application.

3. I certify that (initial applicable paragraphs):

____ a. I possess the credentials and current clinical competence to justify the granting of the staff appointment with clinical privileges as requested.

____ b. I have been provided a copy or access to and have been provided the opportunity to read, and agree to comply with, the facility professional staff policies, procedures and bylaws.

____ c. I have been provided access to and agree to comply with the applicable credentials and privileging directives.

____ d. I have no current mental or physical impairment that could limit my clinical abilities.

____ e. I will notify the privileging authority and my commanding officer, if different from the privileging authority, of any change in my mental or physical condition that could limit my clinical ability or performance.

____ f. I pledge to provide for the continuous care of my patients.

____ g. To my knowledge, I am not currently under investigation involving substandard clinical practice, malpractice or personal misconduct.

4. I authorize (MTF/DTF, or operational site name), its professional staff, and legal representatives, for the purpose of evaluating my professional competence, character, and ethical conduct, to contact and consult with: (initial paragraphs)

____ a. Administrators and members of the professional staff of any other MTF/DTF, institution, or practice with which I have been associated.

____ b. Current or past malpractice carriers.

____ c. My professional colleagues.

5. I consent to the inspection by (MTF/DTF name), its professional staff, and lawful representatives of all records and documents, including health records at other MTFs/DTFs that may be material to evaluation of my professional qualifications for staff membership and clinical privileges.

6. I release from liability all individuals or organizations who respond honestly and in good faith to inquiries authorized in paragraphs 4 and 5.

_____ _____
(Signature) (Date)

Note: Privilege sheets previously approved may be reused when applying for subsequent staff appointments and reappointments if there are no changes in the privileges requested. In such cases, another set of "date requested" and "date approved" blocks must be added to each privilege sheet and completed.

Confirmation of applicant's statement attesting to the ability to perform privileges requested.

_____
Signature

_____
Title

_____
Date

APPENDIX K

SAMPLE APPLICATION FOR TEMPORARY PRIVILEGES WITH OR WITHOUT TEMPORARY MEDICAL STAFF APPOINTMENT

(Date)

From: (Name of practitioner)
To: (Privileging authority)
Via: (1) Medical Staff Services Professional
(2) Appropriate chain of command

Subj: TEMPORARY PRIVILEGES WITH____ OR WITHOUT____TEMPORARY APPOINTMENT

Encl: (1) Clinical privilege sheet or itemized list

1. I am requesting temporary privileges with____ or without____ temporary medical staff appointment.

2. I do_____ or do not_____ have a current mental or physical impairment that could limit my clinical abilities.

3. I understand the temporary privileges with or without temporary medical staff appointment expire 30 days from date of approval.

_____ _____
(Signature) (Date)

ENDORSEMENT PAGE
INITIAL APPOINTMENT WITH CLINICAL PRIVILEGES

Based on consideration of _____'s (*applicant's name*) verified licensure, education and training, ability to perform, current competence as documented in enclosure (2), an interview with a applicant, and compliance with the _____ (department and command's name) appointment and privilege criteria, an initial staff appointment with clinical privileges, as requested, is granted with the expiration date of _____ (not to exceed 1 year from date of approval). Your assigned proctor for this initial appointment is _____.

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Approved
_____ Disapproved
_____ See comments below*

_____
Department Head Signature

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

ACTIVE STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

Based on consideration of _____ (*applicant's name*) verified licensure, education and training, ability to perform, demonstrated current competence in requested privileges as reflected on the attached PAR (Appendix A), and fulfillment of the _____(department and command's name) appointment and privilege criteria, an active staff appointment with clinical privileges, as requested, is granted with an expiration date of _____ (not to exceed 2 years from date of approval).

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Department Head Signature

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Chair, Credentials Committee Signature

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Directorate Signature

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Chair, ECOMS/ECODS Committee Signature

_____
Typed or Printed Name/Date

_____ Approved

_____ Disapproved

_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

ACTIVE STAFF APPOINTMENT WITH CLINICAL PRIVILEGES BASED ON CLINICAL PRIVILEGES HELD AT PREVIOUS COMMAND

Based on consideration of _____(*applicant's name*) verified licensure, education and training, ability to perform, demonstrated current competence at the previous treatment facility as documented in enclosure (2), and fulfillment of the _____ (department and command's name) appointment and privilege criteria, an active staff appointment with clinical privileges, as requested, is granted with an expiration date of _____ (not to exceed 2 years from date of approval).

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ _____
Department Head Signature Chair, Credentials Committee Signature

_____ _____
Typed or Printed Name/Date Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Approved
_____ Disapproved
_____ See comments below*

_____ _____
Directorate Signature Chair, ECOMS/ECODS Committee Signature

_____ _____
Typed or Printed Name/Date Typed or Printed Name/Date

_____ Approved
_____ Disapproved
_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

AFFILIATE STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

Based on consideration of _____ (*applicant's name*) verified licensure, education and training, ability to perform, current competence as documented in enclosure (2), and fulfillment of the _____ (department and command's name) appointment and privilege criteria, an affiliate staff appointment with clinical privileges, as requested, is granted with the expiration date of _____ (not to exceed 2 years from date of approval).

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Department Head Signature

_____
Chair, Credentials Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Directorate Signature

_____
Chair, ECOMS/ECODS Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Approved

_____ Disapproved

_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

RENEWAL OF ACTIVE STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

Based on consideration of _____ (*applicant's name*) verified licensure, education and training, ability to perform, demonstrated current competence in requested privileges as reflected on the attached PAR (Appendix A), and fulfillment of the _____ (department and command's name) appointment and privilege criteria, renewal of the applicant's active staff appointment with clinical privileges, as requested, is granted with an expiration date of _____ (not to exceed 2 years from date of approval).

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Department Head Signature

_____
Chair, Credentials Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Directorate Signature

_____
Chair, ECOMS/ECODS Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Approved

_____ Disapproved

_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE
MODIFICATION OF CLINICAL PRIVILEGES

Based on consideration of _____ (*applicant's name*) verified licensure, education and training, ability to perform, demonstrated current competence, and fulfillment of the _____ (department and command's name) appointment and privilege criteria, a modification, as requested, to the previously approved clinical privileges is granted with an expiration date of _____ (must coincide with the expiration date of the current staff appointment).

List each specialty core privilege set modified:

List each supplemental privilege modified (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Department Head Signature

_____
Chair, Credentials Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____
Directorate Signature

_____
Chair, ECOMS/ECODS Committee Signature

_____
Typed or Printed Name/Date

_____
Typed or Printed Name/Date

_____ Approved

_____ Disapproved

_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

ACTIVE STAFF APPOINTMENT WITH CLINICAL PRIVILEGES ON SUCCESSFUL COMPLETION OF GRADUATE PROFESSIONAL EDUCATION

Based on consideration of _____ (*applicant's name*) verified licensure, education and training, ability to perform, demonstrated current competence in requested privileges as reflected on the attached PAR (Appendix A), and fulfillment of the _____ (department and command's name) appointment and privilege criteria, an active staff appointment with clinical privileges, as requested, is granted with an expiration date of _____ (*not to exceed 2 years from date of approval*).

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not Recommended
_____ See comments below*

_____ _____
Department Head Signature Chair, Credentials Committee Signature

_____ _____
Typed or Printed Name/Date Typed or Printed Name/Date

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not Recommended
_____ See comments below*

_____ _____
Directorate Signature Chair, ECOMS/ECODS Committee Signature

_____ _____
Typed or Printed Name/Date Typed or Printed Name/Date

_____ Approved

_____ Disapproved

_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

ENDORSEMENT PAGE

TEMPORARY CLINICAL PRIVILEGES WITH OR WITHOUT TEMPORARY MEDICAL STAFF APPOINTMENT

Based on consideration of _____ (applicant's name) verified licensure, and current competence, either written or telephonic with appropriate documentation, temporary clinical privileges with/without temporary medical staff appointment, as requested, is granted with the expiration date of _____ (not to exceed 30 days from date of approval).

Name of Command:_____

List each specialty core privilege set requested:

List each supplemental privilege requested (use back of page if necessary)

_____ _____ _____

_____ _____ _____

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ Recommended
_____ Not recommended
_____ See comments below*

_____ _____
Department Head Signature Chair, ECOMS/ECODS Committee Signature

_____ _____
Typed or Printed Name/Date Typed or Printed Name/Date

_____ Approved
_____ Disapproved
_____ See comments below*

_____
Privileging Authority Signature

_____
Typed or Printed Name/Date

* Comments: (Note date and person making comment. Use additional pages as necessary.)

Copy to:
Department Head
Practitioner

APPENDIX L

THERE IS NO APPENDIX L

APPENDIX M

THERE IS NO APPENDIX M

APPENDIX N

DOD INTER-FACILITY CREDENTIALS TRANSFER AND PRIVILEGING BRIEF (ICTB) ON HEALTH CARE PRACTITIONERS

1. When health care practitioners are assigned duty to a facility other than one under the cognizance of their current privileging authority, that authority must convey pertinent credentials and privileging information to the gaining MTF/DTF. This information is used as a basis for authorizing the practitioner to practice upon arrival at the gaining facility. A sample message used to convey the information is found at the end of this appendix. A speed letter, NAVGRAM, fax, or e-mail may also be used but must follow the format of the sample message.

2. The following instructions are provided to assist in completing the items of information in the ICTB:

a. Paragraph 1. Complete name, grade (or rating if civil service), corps, social security number, designator and clinical specialty.

b. Paragraph 2. List qualifying degree, internship, residency, fellowship, and other qualifying training as appropriate. Include completion date of each degree or training and indicate presence/absence of PSV in the ICF. Annotate all items verified with "(v)" after completion date.

c. Paragraph 3. List all State licenses, registrations and certifications, expiration date, and PSV status of each.

d. Paragraph 4. List all applicable specialty/board certifications and re-certifications, expiration date, and PSV status of each.

e. Paragraph 5. List all applicable life-support training (basic cardiac life support (BCLS), advanced cardiac life support (ACLS), advanced trauma life support (ATL)S, pediatric advanced life support (PALS), Neonatal Advanced Life Support (NALS)) and readiness training certification, when developed, and expiration date.

f. Paragraph 6. State the type of appointment (initial, active, affiliate) currently held by the health care provider and the expiration date. List privileges granted or summarize privileges and attach current privilege lists.

g. Paragraph 7. List date of most recent NPDB/HIPDB query and indicate absence or presence of information in the report. Indicate if no query was made.

h. Paragraph 8. Provide a statement of the nature or purpose of the temporary assignment and request PARS as appropriate. (Any ICTB equivalent form used by other health care system privileging authorities shall be accepted by the sending or receiving Navy facility.)

i. Paragraph 9

(1) Provide a brief statement from a supervisory individual personally acquainted with the applicant's professional and clinical performance through observation or review to include quality assessment activities describing the applicant's:

(a) Actual clinical performance with respect to the privileges granted at the sending facility.

(b) Discharge of their professional obligations as a medical staff member.

(c) Ethical performance.

(2) This supervisory individual may be a training program director for new practitioners. The statement may be taken from a current performance evaluation in the provider's ICF; however, the individual making the statement must address whether or not additional relevant information exists pertaining to the above elements and provide a means of direct contact with him/herself (name, title, or position held, telephone number, fax, e-mail address). Relevant information is defined as information that reflects on the current clinical competence of the provider.

j. Paragraph 10. Provide certification that the ICF was reviewed and is accurately reflected in the ICTB as of (annotate the date). This paragraph must contain a statement indicating the presence or absence of other relevant information in the ICF. Supplemental information accompanying PSV of training and licensure is of particular importance. Examples of other relevant information include, but are not limited to: delays in or extensions in training due to marginal performance, unprofessional conduct during training or in previous practice settings, investigations conducted or limitations imposed by State licensing boards, adverse actions, malpractice, etc.

k. Paragraph 11. Provide the name, title, telephone number, fax number and e-mail address of the designated point of contact at the sending facility.

l. Paragraphs applicable to health care providers from reserve or guard components (as needed):

(1) Provide the current civilian position, place of employment, or facility where privileges are held, and the clinical privileges held by the health care provider.

(2) If the HCP is self-employed, provide the health care provider's office location.

(3) If privileges are held at several facilities, provide the name and address of each location where the majority of the practitioner's practice is conducted, and a list of the clinical privileges held which are applicable to the assignment prompting the use of the ICTB.

(4) Include the address, business telephone, home telephone number, fax, and e-mail address where the practitioner can be reached prior to reporting for the assignment and the name of the MTF/DTF and dates of the last tour of clinical duty.

m. Certifying signature by MTF/DTF commander and date. (Use sample message format [pages N-4 through N-7] as a guide when preparing transfer briefs.) Certifying signature may be by electronic signature.

SAMPLE MESSAGE FORMAT

FROM: SENDING FACILITY/UNIT/LOCATION

TO: GAINING FACILITY/UNIT/LOCATION

INFO: CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DETACHMENT (CCPD) FOR RESERVISTS ONLY, NMSC JACKSONVILLE, FL

UNCLAS//N06320//

SUBJ: DOD INTER-FACILITY CREDENTIALS TRANSFER AND PRIVILEGING BRIEF (ICTB)

A. BUMEDINST 6320.66E

1. CDR JOHN C. DOE, MC, USN, 111-22-3333/2100, GENERAL SURGEON

2. EDUCATION/TRAINING	COMPLETION DATE
A. DEGREE: MD	30 JUN 75 (V)
B. INTERNSHIP	30 JUN 76 (V)
C. RESIDENCY, GENERAL SURGERY	25 JUL 82 (V)
D. FELLOWSHIP	01 JAN 90 (V)
E. OTHER QUALIFYING TRAINING	(V)

3. LICENSURE/CERTIFICATION (CURRENT), EXPIRATION DATE, AND REGISTRATION

A. CA 31 DEC 98 (V)

B. MD 15 NOV 98 (V)

4. SPECIALTY BOARD, CERTIFICATION, EXPIRATION DATE, AND RECERTIFICATION

A. AMER BD OF SURGERY	25 JUL 99 (V)

5. CONTINGENCY TRAINING	EXPIRATION DATE
A. BCLS	15 MAR 97
B. ACLS	30 MAR 97
C. ATLS	15 APR 96
D. PALS	23 JUN 96
E. NALS	18 SEP 97

6. CURRENT STAFF APPOINTMENT WITH CLINICAL PRIVILEGES AS NOTED ON THE ICTB AT SENDING FACILITY.

A. PROFESSIONAL STAFF APPOINTMENT EXPIRES: 30 OCT 97

B. CORE PRIVILEGES GRANTED: GENERAL SURGERY

C. SUPPLEMENTAL PRIVILEGES: REPAIR AND RECONSTRUCTION OF VASCULAR ABNORMALITIES, INJURIES, OR DISEASES (INCLUDES PLACEMENT OF VASCULAR GRAFTS AND ARTERIOPLASTIES); ENDOSCOPIC DILATION OR SPHINCTEROTOMY.

7. DATE OF NPDB/HIPDB QUERY: INFORMATION PRESENT OR ABSENT IN DATA BANK.

8. (PROVIDER'S NAME) WILL BE PRACTICING AT YOUR FACILITY ON AN ONGOING BASIS. PLEASE FORWARD A PERFORMANCE APPRAISAL TO THIS COMMAND UPON COMPLETION OF THIS ASSIGNMENT OR BEFORE (DATE), WHICHEVER COMES FIRST.

9. (PROVIDER'S NAME) IS KNOWN TO BE CLINICALLY COMPETENT TO PRACTICE THE FULL SCOPE OF PRIVILEGES GRANTED AT (SENDING FACILITY), TO SATISFACTORILY DISCHARGE HIS/HER PROFESSIONAL OBLIGATIONS, AND TO CONDUCT HIMSELF/HERSELF ETHICALLY, AS ATTESTED BY (NAME, TELEPHONE NUMBER, FAX AND E-MAIL ADDRESS OF THE PROVIDER’S SUPERVISORY INDIVIDUAL (NAME OF PERSON GIVING RECOMMENDATION) HAS OR DOES NOT HAVE ADDITIONAL INFORMATION RELATING TO (PROVIDER'S NAME) COMPETENCE TO PERFORM GRANTED PRIVILEGES. (WHEN ADDITIONAL INFORMATION EXISTS, THE GAINING FACILITY MUST BE INSTRUCTED TO COMMUNICATE WITH THE POINT OF CONTACT FOR THE PURPOSE OF EXCHANGING THE ADDITIONAL INFORMATION).

10. PROVIDER'S ICF AND THE DOCUMENTS CONTAINED THEREIN HAVE BEEN REVIEWED AND VERIFIED AS INDICATED ABOVE. THE INFORMATION CONVEYED IN THIS LETTER/MESSAGE REFLECTS CREDENTIALS STATUS AS OF (DATE). (CHOOSE FROM THE FOLLOWING SENTENCE FORMATS, OR

VARIATIONS THEREOF, TO DESCRIBE THE PRESENCE/ABSENCE OF ADDITIONAL INFORMATION IN THE ICF): (1) THE ICF CONTAINS NO ADDITIONAL INFORMATION RELEVANT TO THE PRIVILEGING OF THE PROVIDER IN THE MTF/DTF, OR (2) THE ICF CONTAINS ADDITIONAL RELEVANT INFORMATION REGARDING STATUS OF CURRENT LICENSE; OR (3) THE ICF CONTAINS ADDITIONAL RELEVANT INFORMATION THAT MAY REFLECT ON THE CURRENT COMPETENCE OF THE PROVIDER. CONTACT THIS COMMAND FOR FURTHER INFORMATION BEFORE TAKING APPOINTING AND PRIVILEGING ACTION.

11. POC: NAME, TITLE, TELEPHONE NUMBER, FAX NUMBER AND E-MAIL ADDRESS.

12. RESERVE OR GUARD HEALTH CARE PROVIDER: (PROVIDER'S NAME) CURRENTLY HOLDS PRIVILEGES IN (SPECIALTY[IES]) AT (HOSPITAL[S] NAME, ADDRESS). PROVIDER MAY BE REACHED AT (OFFICE MAILING ADDRESS, OFFICE TELEPHONE, FAX, AND E-MAIL ADDRESS, HOME TELEPHONE). (ENSURE THIS INFORMATION IS ACCURATE BEFORE SENDING).

13. CERTIFIED BY: (COMMANDER AND DATE)

APPENDIX O

SAMPLE FORMAT CREDENTIALS AND PRIVILEGING INQUIRY

6320
(Date)

From: (Privileging Authority and address)
To: Facility holding privileges (Attn: Professional Affairs Office)

Subj: CREDENTIALS/PRIVILEGING INQUIRY REGARDING (practitioner's name, specialty, department, and position)

Encl: (1) Release of Liability Authorization Signed by Practitioner

1. General Information. (Practitioner's name) has authorized in enclosure (1) this inquiry concerning his/her current practice at your facility. Please provide the information requested below and return this letter to the Medical Staff Services Professional (insert address).

2. Scope of Care

a. A copy of the practitioner's privileges held at your facility.

b. Volume data for past 2 years

(1) ___# of admissions.
(2) ___# of outpatient visits.
(3) ___# of major or selected procedures.
(4) ___# of days unavailable due to TAD, deployment, etc.

3. Current Competence

a. Professional (past 2 years).

(1) Surgical/invasive/noninvasive case reviews.

(2) Blood usage review.

(3) Drug usage review.

(4) Medical record pertinence review.

(5) Medical record peer review.

_____# reviewed _____# deficient

b. Facility-wide monitors (past 2 years) (circle appropriate mark).

(1) Utilization management. Sat Unsat

(2) Infection control. Sat Unsat

(3) Patient contact/satisfaction program. Sat Unsat

(4) Number of liability claims, investigations, and health care reviews in which practitioner was principle focus.

c. Professional development (past 2 years).

(1) ___# of continuing education credit hours.

(2) ___# of papers published and professional presentations.

d. Evaluation (circle appropriate mark).

(1) Basic professional knowledge. Sat Unsat Not Obs

(2) Technical skill and competence. Sat Unsat Not Obs

(3) Professional judgment. Sat Unsat Not Obs

(4) Ethical conduct. Sat Unsat Not Obs

(5) Practitioner-patient relations. Sat Unsat Not Obs

(6) Participation in staff, department and committee meetings. Sat Unsat Not Obs

(7) Ability to work with peers and support staff. Sat Unsat Not Obs

(8) Ability to supervise peers and support staff.

4. Health Status Inquiry. Required modification of practice due to health status (indicate yes or no).

5. Adverse Actions or Trends. If the answer to any of the following is "Yes," pertaining to your facility only, provide full details on a separate sheet of paper and attach to this letter. Identify items by section and letter. To your knowledge, has the practitioner: (indicate yes or no)

___ a. Had privileges adversely denied, suspended, limited or revoked?

___ b. Had privileges nonadversely reduced?

___ c. Required counseling, additional training or special supervision?

___ d. Failed to obtain appropriate consultation?

___ e. Had significant trends (positive or negative) in clinical performance identified through the facility occurrence screening program or other monitors?

6. Summary Recommendation. (Place "X" by appropriate item)

___ a. I recommend this practitioner without reservation for appointment to your professional staff.

___ b. I recommend this practitioner with comments (see additional sheet).

___ c. I do not recommend this practitioner.

7. Point of Contact. Thank you for your objective response to these questions. On a separate sheet of paper, please provide your candid evaluation of this practitioner's clinical competency, as you have observed, and any other comments that will assist in this evaluation. If you have any questions or comments about this inquiry, my point of contact is (name, office address, telephone number, fax and e-mail address) _____.

_____
Signature

APPENDIX P

THERE IS NO APPENDIX P

APPENDIX Q
SAMPLE FORMAT REQUEST TO EXERCISE CLINICAL PRIVILEGES

(Date)

From: Grade/Name/Service/SSN/Designator of Practitioner
To: Privileging authority for gaining command

Subj: REQUEST FOR AUTHORITY TO EXERCISE CLINICAL PRIVILEGES

Ref: (a) BUMEDINST 6320.66E
(b) BUMEDINST 6010.17B

Encl: (1) Credentials and Privileging Information on Health Care Practitioners, Appendix N (ICTB)

1. Per reference (a), and based on the active staff appointment with clinical privileges granted by (holder of ICF) as documented in enclosure (1), I respectfully request authority to exercise my core privileges in (gaining facility) for the period _____ to _____.

2. If granted subject authority, I agree to comply with reference (b) and the policies and procedures of (gaining facility).

_____
Signature

DEPARTMENT HEAD ENDORSEMENT

(Date)

From: Head, (gaining) Department
To: Privileging authority for gaining facility

1. Following review of enclosure (1) and an interview with (practitioner), I recommend he/she be authorized to exercise clinical privileges as requested.

_____
Signature

PRIVILEGING AUTHORITY'S ACTION
(gaining facility)
(Date)

1. Approved _____ Disapproved _____

2. Expiration date: _____

_____
Signature

Copy to:
Department Head
Medical Staff Services Professional
Chair, Credentials Committee/ECOMS/ECODS

APPENDIX R

INDIVIDUAL CREDENTIALS FILE - STRUCTURE AND CONTENTS

1. A six section (Federal Stock Number 7530-00-990-8884) ICF shall be maintained for each health care practitioner including contract or resource sharing agreement and clinical support providers from the time of accession or employment throughout the practitioner's tenure with the DON. The ICF in its entirety, folder included, will be forwarded following the procedures listed in section 4.

2. Primary source verification is critical to the credentials process. It is the verification of the credential that must be in the ICF; not the actual credential. If the credential is included in the ICF, the verification must be attached to the document.

3. The ICF will be structured as follows with each section listed from bottom to top of section:

a. Section I. Background Information (inside front cover)

(1) Photograph. A representative, recent photograph (official Navy photograph, passport or instant photograph), labeled with the practitioner's name and date taken, to be submitted with the initial PPIS. Photograph shall be updated as necessary to enable positive, visual identification of the practitioner.

(2) Appendix J, PPIS. All updates, in chronological order, with the most recent on top.

(3) The computer disk, if used to maintain the PPIS.

(4) Appendix I, PAS.

b. Section II. Current Practice Information

(1) A copy of Appendix N (ICTB), attached to the PAR received upon completion of TAD, for all TAD completed during the current permanent duty assignment shall be inserted in chronological order.

(2) All clinical privileges granted by the current privileging authority. The appropriate privilege sheets, Appendices E through H, the Application for Professional Staff Appointment with Clinical Privileges with endorsements, Appendix K, and any associated PARs (with related JAGMAN summaries attached) shall be stapled together, maintained as a unit, and filed chronologically with the most current on top.

c. Section III. Professional Education and Training

(1) Qualifying degree: evidence of qualifying degrees needed for the performance of clinical privileges, e.g., MD, DO, DDS, DMD, PhD, and MSW. For physician graduates of foreign medical schools, other than approved schools in Canada and Puerto Rico, evidence of passing either the FMGEMS or the examination of the ECFMG constitutes evidence of the qualifying degree. Degree must be verified, and can be attached to the document.

(2) PSV of postgraduate civilian and Navy training (e.g., internship, residency, fellowship, nurse anesthesia) in chronological order with the most recent on top. Verification of Navy inservice training program completion, and civilian outservice training completion must be primary source verified, to include current competency attested to by the Navy PAR, and/or the civilian program director or designee.

(3) National or American specialty board certifications must be verified, can be attached to document. National Board of Medical Examiner certificates are not required in the ICF.

d. Section IV. Licensure and State and national certifica-tion. Evidence of all State licenses or certifications (e.g., Council on Certification of Nurse Anesthetists or Certified Registered Nurse Anesthetist, NCCPA for PAs, and ACSW for social workers) held within the last 10 years, in chronological order. Verification can be attached to or in lieu of the license/ certification document. Current licenses or certifications shall be on top.

e. Section V. Professional experience. Letters of reference, including responses to credential and privilege inquiries, previous privileges with all associated documents (applications, endorsements, and PARs attached), previous ICTB's (with associated PARs attached), and documentation of training specifically supporting the granting of supplemental privileges shall be filed chronologically with the most recent on top.

f. Section VI. Other practice information. All information is to be filed in chronological order with most recent on top.

(1) Documentation of any, military or civilian, adverse privileging actions and reportable misconduct. Disciplinary actions by professional regulatory agencies.

(2) Documentation of all medical malpractice claims, settlements, or judicial or administrative adjudications with a brief description of the facts of each case.

(3) Inquiries with responses to professional clearing houses, as appropriate, e.g., Federation of State Medical Boards and NPDB/HIPDB. For physicians and dentists in the Navy health care system on the effective date of this instruction, reports from the NPDB/HIPDB shall be obtained at intervals not to exceed 2 years.

APPENDIX S

INDIVIDUAL PROFESSIONAL FILE - STRUCTURE AND CONTENTS

1. A six section (Federal Stock Number 7530-00-990-8884) individual professional file (IPF) shall be maintained for each naval clinical support staff member including contract or resource sharing agreement and clinical support providers from the time of accession or employment throughout the member's tenure with the DON. The IPF in its entirety (folder included) must be established, maintained, and transmitted following the procedures listed in Section 3 and paragraphs 3 and 5 of Section 4.

2. Primary source verification is critical to the credentials process. It is the verification of the credential that must be in the IPF; not the actual credential. If the credential is included in the IPF, the verification must be attached to the document.

3. The IPF must be structured as follows with each section listed from bottom to top of section:

a. Section I. Background information (inside front cover).

(1) Photograph. A representative, recent photograph (official Navy photograph, passport or instant photograph), labeled with the provider's name and date taken, to be submitted with the initial PPIS. Photograph shall be updated as necessary to enable positive, visual identification of the practitioner.

(2) Appendix J, PPIS. All updates, in chronological order, with the most recent on top. Nurse specialists may use applicable pages from Appendix J.

(3) The computer disk, if used to maintain the PPIS.

(4) Appendix I, PAS.

b. Section II. Current practice information. All clinical appraisal reports by the current duty station, filed chronologically with the most current on top.

c. Section III. Professional education and training. Qualifying degree: PSV of qualifying degrees (e.g., BS, BSN, and diploma from a nursing education program). PSV of postgraduate training in chronological order with the most recent on top.

d. Section IV. Licensure and certification. Evidence of all State licenses or State certifications (e.g., registered nurse) held within the last 10 years, in chronological order. Verification of each license must be in credentials file. Verification can be attached to or

in lieu of the license document. When certification is required, instead of a license, verification is required. Clinical support staff nursing certifications that are not equivalent to licensure, do not have to be independently verified. Current license verification or certification verifications shall be on top.

e. Section V. Professional experience. Letters of reference, including responses to inquiries and previous clinical appraisal reports, shall be filed chronologically with the most recent on top.

f. Section VI. Other practice information. All information shall be filed in chronological order with most recent on top.

(1) Documentation of any military or civilian adverse clinical actions or reportable misconduct. Disciplinary actions by professional regulatory agencies.

(2) Documentation of all medical malpractice claims, settlements, or judicial or administrative adjudications with a brief description of the facts of each case.

(3) Inquiries with responses to professional regulatory agencies.